

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<p>I. IDPH Facility ID Number: <u>0032896</u></p> <p>Facility Name: <u>Alden Poplar Creek Rehab & HCC</u></p> <p>Address: <u>1545 Barrington Road</u> <u>Hoffman Estates</u> <u>60194</u> Number City Zip Code</p> <p>County: <u>Cook</u></p> <p>Telephone Number: <u>(847) 884-0011</u> Fax # <u>(847) 884-0121</u></p> <p>IDPA ID Number: <u>36 - 3299486</u></p> <p>Date of Initial License for Current Owners: <u>01/01/88</u></p> <p>Type of Ownership:</p> <table border="0"> <tr> <td><input type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input checked="" type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code _____</td> <td><input checked="" type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table> <p>In the event there are further questions about this report, please contact: Name: <u>Steven M. Kroll</u> Telephone Number: <u>(773) 286-3883</u></p>	<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code _____	<input checked="" type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<p>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</p> <p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p> <table border="1"> <tr> <td data-bbox="1150 678 1283 829" rowspan="2">Officer or Administrator of Provider</td> <td data-bbox="1283 678 1921 727">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1283 727 1921 808">(Type or Print Name) <u>STEVEN M. KROLL</u> (Title) _____</td> </tr> <tr> <td data-bbox="1150 829 1283 1040" rowspan="4">Paid Preparer</td> <td data-bbox="1283 829 1921 878">(Signed) _____ (Date) _____</td> </tr> <tr> <td data-bbox="1283 878 1921 927">(Print Name and Title) _____</td> </tr> <tr> <td data-bbox="1283 927 1921 976">(Firm Name & Address) _____</td> </tr> <tr> <td data-bbox="1283 976 1921 1040">(Telephone) <u>()</u> Fax # ()</td> </tr> </table> <p align="center">MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</p>	Officer or Administrator of Provider	(Signed) _____ (Date) _____	(Type or Print Name) <u>STEVEN M. KROLL</u> (Title) _____	Paid Preparer	(Signed) _____ (Date) _____	(Print Name and Title) _____	(Firm Name & Address) _____	(Telephone) <u>()</u> Fax # ()
<input type="checkbox"/> VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																															
<input type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																															
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	(Firm Name & Address) _____																																
	(Telephone) <u>()</u> Fax # ()																																

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Alden Poplar Creek Rehab & HCC# 0032896 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>217</u>	Skilled (SNF)		<u>79,205</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>217</u>	TOTALS		<u>79,205</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,042</u>	<u>3,095</u>	<u>12,363</u>	<u>20,500</u>	8
9	SNF/PED					9
10	ICF	<u>33,020</u>	<u>5,502</u>	<u>1,473</u>	<u>39,995</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>38,062</u>	<u>8,597</u>	<u>13,836</u>	<u>60,495</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 76.38%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)day care

F. Does the facility maintain a daily midnight census?

yesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 05/01/88

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 11/12/95NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒NO ☐

If YES, enter number

of beds certified 78and days of care provided 11,297Medicare Intermediary Administar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Alden Poplar Creek Rehab & HCC # 0032896 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	365,192	30,075	10,799	406,066	1,482	407,548		407,548			1
2	Food Purchase		363,589		363,589	(37,893)	325,696	13,761	339,457			2
3	Housekeeping	177,274	33,590		210,864	540	211,404		211,404			3
4	Laundry	57,671	16,989		74,660	285	74,945		74,945			4
5	Heat and Other Utilities			216,194	216,194		216,194	1,217	217,411			5
6	Maintenance	53,589	251	153,744	207,584		207,584	11,681	219,265			6
7	Other (specify):* Security			214	214		214		214			7
8	TOTAL General Services	653,726	444,494	380,951	1,479,171	(35,586)	1,443,585	26,659	1,470,244			8
	B. Health Care and Programs											
9	Medical Director			35,700	35,700		35,700		35,700			9
10	Nursing and Medical Records	3,080,419	200,665	7,648	3,288,732	4,209	3,292,941	(80,182)	3,212,759			10
10a	Therapy	41,615			41,615		41,615		41,615			10a
11	Activities	44,218	1,705	3,828	49,751	187	49,938	(8,362)	41,576			11
12	Social Services	37,983			37,983		37,983		37,983			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	3,204,235	202,370	47,176	3,453,781	4,396	3,458,177	(88,544)	3,369,633			16
	C. General Administration											
17	Administrative	183,912			183,912		183,912		183,912			17
18	Directors Fees											18
19	Professional Services			651,321	651,321		651,321	(584,906)	66,415			19
20	Dues, Fees, Subscriptions & Promotions			58,935	58,935		58,935	(46,081)	12,854			20
21	Clerical & General Office Expenses	495,981	15,110	127,046	638,137		638,137	(32,242)	605,895			21
22	Employee Benefits & Payroll Taxes			659,396	659,396	31,190	690,586	57,613	748,199			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,708	3,708		3,708	12,621	16,329			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			140,058	140,058		140,058	12,608	152,666			26
27	Other (specify):* bad debt			(149,200)	(149,200)		(149,200)	149,200				27
28	TOTAL General Administration	679,893	15,110	1,491,264	2,186,267	31,190	2,217,457	(431,187)	1,786,270			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	4,537,854	661,974	1,919,391	7,119,219		7,119,219	(493,072)	6,626,147			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number Alden Poplar Creek Rehab & HCC #0032896 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			70,163	70,163		70,163	365,088	435,251			30
31	Amortization of Pre-Op. & Org.							3,538	3,538			31
32	Interest			736,505	736,505		736,505	(52,287)	684,218			32
33	Real Estate Taxes							584,399	584,399			33
34	Rent-Facility & Grounds			1,381,158	1,381,158		1,381,158	(1,381,158)				34
35	Rent-Equipment & Vehicles			15,595	15,595		15,595	23,263	38,858			35
36	Other (specify):* Mortgage Insurance Premium							49,489	49,489			36
37	TOTAL Ownership			2,203,421	2,203,421		2,203,421	(407,668)	1,795,753			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		638,129	820,323	1,458,452		1,458,452	(297,817)	1,160,635			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,807	118,807		118,807		118,807			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		638,129	939,130	1,577,259		1,577,259	(297,817)	1,279,442			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	4,537,854	1,300,103	5,061,942	10,899,899		10,899,899	(1,198,557)	9,701,342			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$ (8,362)	11	\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(314)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,960)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(63,282)	21		17
18	Fines and Penalties	(225)	32		18
19	Entertainment	(944)	20		19
20	Contributions	(1,950)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(14,884)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	149,200	27		24
25	Fund Raising, Advertising and Promotional	(39,249)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ 17,030		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(396,373)	Various	34
35	Other- Attach Schedule	(819,214)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (1,215,587)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (1,198,557)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Poplar Creek Rehab & HCC

ID# 0032896

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	Back out prior year depreciation adj-equipment	\$ (419)	30 1
2	Reclass vendor settlements from Line 21 to Line 6	(7,837)	6 2
3	Reclass vendor settlements from Line 21 to Line 6	7,837	21 3
4	Back out prior yr cr adj in 7143 for hvac/misc repairs	7,837	6 4
5	Reclass vendor settlements from Line 21 to Line 10	(580)	10 5
6	Reclass vendor settlements from Line 21 to Line 10	580	21 6
7	Back out prior yr cr adj in 7143 for hvac/misc repairs	580	10 7
8	Back out 30.13% from IHCA	(3,531)	20 8
9	Back out one month pmt for 2002 to IHCA	(977)	20 9
10	Late fees on utilities	(2,543)	5 10
11			11
12			12
13	Back out related party interest exp (AMS-FAS Interest GI	(721,584)	32 13
14	Medical Records (GL 4977)	(189)	21 14
15	Pop Machine (GL 4977)	(278)	2 15
16	Depreciation on Deferred Maintenance "Painting"	1,123	6 16
17	Back out Marketing Salaries	(53,222)	21 17
18	Back out related party interest exp (AMS-PC LLC Interes	(37,107)	32 18
19	Back out bank charges in Poplar Creek LLC	(25)	21 19
20	Marketing Employ. Benefits deduction	(8,879)	22 20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(819,214)	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,238)	0	0	16,999	0	0	0	0	0	0	0	13,761	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(2,543)	0	3,760	0	0	0	0	0	0	0	0	1,217	5
6	Maintenance	1,123	0	12,210	0	0	0	(85)	(1,567)	0	0	0	11,681	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,658)	0	15,970	16,999	0	0	(85)	(1,567)	0	0	0	26,659	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(79,508)	(674)	0	0	0	0	0	0	(80,182)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(8,362)	0	0	0	0	0	0	0	0	0	0	(8,362)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(8,362)	0	0	(79,508)	(674)	0	0	0	0	0	0	(88,544)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(14,884)	4,890	(574,912)	0	0	0	0	0	0	0	0	(584,906)	19
20	Fees, Subscriptions & Promotions	(46,651)	0	570	0	0	0	0	0	0	0	0	(46,081)	20
21	Clerical & General Office Expenses	(108,301)	25	33,521	26,174	16,339	0	0	0	0	0	0	(32,242)	21
22	Employee Benefits & Payroll Taxes	(8,879)	0	62,768	0	3,724	0	0	0	0	0	0	57,613	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	12,621	0	0	0	0	0	0	0	0	12,621	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	12,315	293	0	0	0	0	0	0	0	0	12,608	26
27	Other (specify):*	149,200	0	0	0	0	0	0	0	0	0	0	149,200	27
28	TOTAL General Administration	(29,515)	17,230	(465,139)	26,174	20,063	0	0	0	0	0	0	(431,187)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(42,535)	17,230	(449,169)	(36,335)	19,389	0	(85)	(1,567)	0	0	0	(493,072)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	D. Ownership												
30	Depreciation	(419)	353,102	10,584	0	1,821	0	0	0	0	0	0	365,088 30
31	Amortization of Pre-Op. & Org.	0	1,662	1,697	0	0	179	0	0	0	0	0	3,538 31
32	Interest	(759,230)	655,013	50,161	0	1,498	271	0	0	0	0	0	(52,287) 32
33	Real Estate Taxes	0	576,726	7,050	0	623	0	0	0	0	0	0	584,399 33
34	Rent-Facility & Grounds	0	(1,381,158)	0	0	0	0	0	0	0	0	0	(1,381,158) 34
35	Rent-Equipment & Vehicles	0	0	23,263	0	0	0	0	0	0	0	0	23,263 35
36	Other (specify):*	0	49,489	0	0	0	0	0	0	0	0	0	49,489 36
37	TOTAL Ownership	(759,649)	254,834	92,755	0	3,942	450	0	0	0	0	0	(407,668) 37
	Ancillary Expense												
	E. Special Cost Centers												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(46,846)	(70,421)	(180,550)	0	0	0	0	0	(297,817) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	TOTAL Special Cost Centers	0	0	0	(46,846)	(70,421)	(180,550)	0	0	0	0	0	(297,817) 44
	GRAND TOTAL COST												
45	(sum of lines 29, 37 & 44)	(802,184)	272,064	(356,414)	(83,181)	(47,090)	(180,100)	(85)	(1,567)	0	0	0	(1,198,557) 45

Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Management Services	100%	See Pg 6K		See Pg 6K		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	34 Rent income	\$ 1,381,158	Poplar Creek LLC		\$	\$ (1,381,158)
2	V	32 Investment Income - RR	255				(255)
3	V	19 Miscellaneous Costs				5	5
4	V	19 Accounting Fees				4,000	4,000
5	V	21 Bank charges				25	25
6	V	19 Licenses & Inspections				885	885
7	V	33 Real Estate taxes				576,726	576,726
8	V	26 General Insurance Expense				12,315	12,315
9	V	36 Mortgage insurance premium				49,489	49,489
10	V	32 Interest on mortgage				618,161	618,161
11	V	32 Interest on amount due to AMS				37,107	37,107
12	V	30 Depreciation Expense				353,102	353,102
13	V	31 Amortization Expense				1,662	1,662
14	Total		\$ 1,381,413			\$ 1,653,477	\$ * 272,064

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	19 management fees	\$ 591,600	Alden Management Services		\$	\$ (591,600)	15
16	V	22 employee benefits		Alden Management Services		62,768	62,768	16
17	V	19 professional fees		Alden Management Services		16,688	16,688	17
18	V	21 gen'l & admin		Alden Management Services		33,521	33,521	18
19	V	5 utilities		Alden Management Services		3,760	3,760	19
20	V	6 maintenance		Alden Management Services		12,210	12,210	20
21	V	24 travel & seminar		Alden Management Services		12,621	12,621	21
22	V	26 insurance		Alden Management Services		293	293	22
23	V	20 dues & subscriptions		Alden Management Services		570	570	23
24	V	30 depreciation		Alden Management Services		10,584	10,584	24
25	V	31 amortization		Alden Management Services		1,697	1,697	25
26	V	33 real estate tax		Alden Management Services		7,050	7,050	26
27	V	34 rent-facilities		Alden Management Services				27
28	V	35 rent-equip & vehicles		Alden Management Services		23,263	23,263	28
29	V	32 interest		Alden Management Services		50,161	50,161	29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 591,600			\$ 235,186	\$ * (356,414)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 tube-feeding	\$ 14,862	Pyramid Health Care	100.00%	\$ 31,861	\$ 16,999	15
16	V	10 nursing supplies	86,986	Pyramid Health Care		7,478	(79,508)	16
17	V	39 perdiems/other supplies	101,840	Pyramid Health Care		54,994	(46,846)	17
18	V	21 gen'l & admin		Pyramid Health Care		26,174	26,174	18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 203,688			\$ 120,507	\$ * (83,181)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	39 drugs	\$ 288,341	Forum Extended Care II		\$ 243,593	\$ (44,748)
16	V	10 house stock	4,340	Forum Extended Care II		3,666	(674)
17	V	39 I. V.	165,427	Forum Extended Care II		139,754	(25,673)
18	V	22 employee benerfits		Forum Extended Care II		3,724	3,724
19	V	21 gen't & admin		Forum Extended Care II		16,339	16,339
20	V	32 interest		Forum Extended Care II		1,498	1,498
21	V	33 real estate tax		Forum Extended Care II		623	623
22	V	30 depreciation		Forum Extended Care II		1,821	1,821
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 458,108			\$ 411,018	\$ * (47,090)

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 therapy	\$ 792,013	Community Physical Therapy	100.00%	\$ 611,463	\$ (180,550)	15
16	V	32 interest		Community Physical Therapy		271	271	16
17	V	31 amortization		Community Physical Therapy		179	179	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 792,013			\$ 611,913	\$ * (180,100)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Poplar Creek Rehab & HCC# 0032896Report Period Beginning: 01/01/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 repairs and maintenance	\$ 26,560	Alden Bennett Construction		\$ 26,475	\$ (85)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 26,560			\$ 26,475	\$ * (85)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 CARPET CLEANING	\$ 19,372	ALDEN REALTY - CARPET CARE		\$ 18,028	\$ (1,344)	15
16	V	6 FLOOR CLEANING	3,920	ALDEN REALTY - FLOOR CARE		3,697	(223)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 23,292			\$ 21,725	\$ * (1,567)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS

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Facility Name & ID Number ALDEN NURSING CENTER - POPLAR CREEK

003-2896

Report Period Beginning 01/01/03

Ending: 12/31/03

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomingtondale
ANC Village for Children & Young Adults	Bloomingtondale
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomingtondale
Alden of Old Town West	Bloomingtondale
Alden Trails	Bloomingtondale
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Alma Nelson	Rockford
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Waterford	Aurora
ANC Governors' Park	Barrington

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living

STATE OF ILLINOIS

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Facility Name & ID Number Alden Poplar Creek Rehab & HCC # 0032896 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	CEO	100.00	327,008	2.256	5.64	Salary	\$ 19,544	17-1	1
2	Lauren Magnusson b.	Nurse coordinator	nursing admin		82,155	2.256	5.64	Salary	4,910	10-1	2
3	Terry Magnusson c.	Maint. Supervisor	construct/maint		79,446	2.256	5.64	Salary	4,748	6-1	3
4											4
5											5
6	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc.										6
7	b. Lauren is the daughter of Floyd Schlossberg										7
8	c. Terry is the son-in-law of Floyd Schlossberg										8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 29,202		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Poplar Creek Rehab & HCC # 0032896 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.
 Street Address 4200 W. Peterson Ave.
 City / State / Zip Code Chicago, IL 60646
 Phone Number (773) 286-3883
 Fax Number (773) 286-3743

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	see page 8A (also on page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Cambridge		x	mortgage	\$58,310.00	9/2002	\$ 9,875,100	\$ 9,774,465	12/2037	6.3000	\$ 618,161	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	related party-ams& ams therap	x		working capital							64,857	6	
7	related party-cpt	x		working capital							271	7	
8	related party-fecII	x		working capital							1,498	8	
9	TOTAL Facility Related				\$58,310.00		\$ 9,875,100	\$ 9,774,465			\$ 684,787	9	
	B. Non-Facility Related*												
10	offset Cicero Assoc interest expense with interest income on Repl reserve										(255)	10	
11												11	
12	offset Interest expense with Interest Income (GL4946,4983)										(314)	12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (569)	14	
15	TOTALS (line 9+line14)						\$ 9,875,100	\$ 9,774,465			\$ 684,218	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 49,489 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Alden Poplar Creek Rehab & HCC**# **0032896** Report Period Beginning: **01/01/2003** Ending: **12/31/2003****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2002 report.		\$ 574,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$ 567,026	2
3. Under or (over) accrual (line 2 minus line 1).		\$ (7,374)	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ 584,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$ 576,726	7
Real Estate Tax History:			
Real Estate Tax Bill for Calendar Year:	1998 515,710	8	
	1999 517,127	9	
	2000 524,839	10	
	2001 557,622	11	
	2002 567,026	12	
accrual based on 3% increase over prior yr bill.			
		13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
		14	PLUS APPEAL COST FROM LINE 5 \$ 14
		15	LESS REFUND FROM LINE 6 \$ 15
		16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Alden Poplar Creek Rehab & HCC COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0032896

CONTACT PERSON REGARDING THIS REPORT Steven M. Kroll

TELEPHONE (773) 286-3883 FAX #: (773) 286-3743

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>07-07-300-012-0000</u>	<u>Nursing home facility</u>	\$ <u>567,025.96</u>	\$ <u>567,025.96</u>
2. _____	<u>Related Party - Alden Management</u>	\$ <u>125,008.00</u>	\$ <u>7,050.00</u>
3. _____	<u>Related Party - Forum</u>	\$ <u>8,317.00</u>	\$ <u>623.00</u>
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u><u>700,350.96</u></u>	\$ <u><u>574,698.96</u></u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A.

Square Feet:

249,325

B.

General Construction Type:

Exterior

brick

Frame

steel

Number of Stories

3

C.

Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D.

Does the Operating Entity?

☐ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E.

List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F.

Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Patient care	62,115	1978	\$ 90,580	1
2					2
3	TOTALS	62,115		\$ 90,580	3

Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

XL OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	Related party-Forum			1978	\$ 15,909	\$	22	\$	\$	15,909	4
5											5
6	217		1995	1988	9,202,500	230,062	40	230,062		1,872,517	6
7											7
8											8
	Improvement Type**										
9	Electrical work/deoc/construction/fire alarm			1988	34,647		5-10			34,647	9
10	Sink repair/painting/marble work/class/electrical			1989	142,814		5-10			142,814	10
11	Install pump/village street signal/heater motor			1990	12,416	600	5-15	600		12,290	11
12	Replace boiler/replace a/c unit/replace condensor			1991	11,622	521	5-15	521		10,275	12
13	Flooring/clean condensor/roto-rooter/sprinkler/pump			1992	15,458	199	5-25	199		12,857	13
14	HVAC/electrical work/flooring/fan/counter /cabinets			1993	72,195	4,399	5-20	4,399		57,853	14
15	HVAC/prior credits applied			1994	(5,559)	96	10-15	96		871	15
16	A/C work/electricity repair/HVAC repairs			1995	23,105	1,523	5-15	1,523		15,146	16
17	Increase lighting levels on first floor			1996	8,838	589	15	589		4,222	17
18	Repair and epoxy all shower bases			1996	7,164	478	15	478		3,424	18
19	Clean coils to existing NU-AHL			1996	7,164	717	10	717		5,374	19
20	Laundry-enclose dryer area, door etc.			1996	7,763	388	20	388		2,814	20
21	Redesign PT,OT, activity area			1996	11,943	597	20	597		4,479	21
22	Repair restucco 2 entrance monuments			1996	5,014	502	10	502		3,595	22
23	Remove & replace roof with new			1996	89,573	4,479	20	4,479		32,470	23
24	Replace 2-25 gallon 450 BTU hot water heaters			1996	41,801	2,787	15	2,787		20,436	24
25	Add alternate biler phasing standby/back			1996	5,972	398	15	398		2,887	25
26	Change roof exhausts			1996	13,137	876	15	876		6,423	26
27	Repaint all painted surfaces in soda shop			1996	1,850		5			1,850	27
28	Add pantries w/kitchen equip to 1,2,3rd floors			1996	122,492	6,125	20	6,125		44,403	28
29	Siegert (sprinkler system)			1996	29,000	1,933	15	1,933		14,983	29
30	Tri-star install cooler assec.			1997	1,864		5			1,864	30
31	Cummis/onan -install pump			1997	4,959		5			4,959	31
32	Network environment -repair pipe			1997	8,000		5			8,000	32
33	Network environment -repair pipe			1997	6,800		5			6,800	33
34	A&B install cable in all rooms			1997	4,680	468	10	468		2,925	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

		3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38	Wigdahl electric-insall outlet and lights	1998	1,778		5			1,778	38
39	A&B custom cable install cable tv 2nd floor rooms	1998	4,680		5			4,680	39
40	CSI-maint. On choller and clean condensor valves	1998	8,400	840	10	840		4,620	40
41	CSI -repair compressor and freon	1998	2,330	155	15	155		828	41
42	CSI-repair condensing unit on cooler	1998	1,869	187	10	187		997	42
43	ABC	1998	1,748,376	47,253	5-20	47,253		278,971	43
44	ABC	1998	13,080	1,308	10	1,308		6,649	44
45	Alpha Sign-signs and plaques	1999	9,881	494	20	494		2,264	45
46	CSI-repair condensor	1999	1,528	153	10	153		662	46
47	Fos valley fire & safety-smoke detectors	1999	6,502	650	10	650		2,709	47
48	CSI-repair boiler	1999	1,875	125	15	125		521	48
49	CSI-compressor	1999	1,531	102	15	102		417	49
50	Equipment Int.-washing machine	1999	1,936	387	5	387		1,581	50
51	ABC-concrete, fencing	1999	12,735	849	15	849		3,467	51
52	Climate Services, -replace coil/thermostat	1999	5,425	543	10	543		2,713	52
53	DBS contracting-install lawn sprinkler system	2000	1,863	124	15	124		435	53
54	New Horizons	2000	525	73	3	73		525	54
55	New Horizons	2000	667	130	3	130		667	55
56	New Horizons	2000	714	119	3	119		714	56
57	New Horizons	2000	824	160	3	160		824	57
58	Alden Design	2000	4,440	222	20	222		740	58
59	Alden Design	2000	5,500	275	20	275		894	59
60	Walter Mayer -interior finishes	2000	4,000	267	15	267		1,022	60
61	CSI-window treatment	2000	19,411	3,882	5	3,882		14,558	61
62	DBS contracting - Alden sign	2000	1,500	300	5	300		1,125	62
63	Equipment Int.-repair dryer	2000	1,864	207	3	207		1,864	63
64	A&B custom cable install cable tv 1st floor rooms	1998	5,760		5			5,760	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 11,772,115	\$ 316,541		\$ 316,541	\$	\$ 2,689,072	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12A, Carried Forward		\$ 11,772,115	\$ 316,541		\$ 316,541		\$ 2,689,072		1
2	Equipment Int. -repair dryer	2000	926	129	3	129		926		2
3	GT Mechanical-repair cooler and freezer doors	2000	1,530	306	5	306		1,045		3
4	CSI-Coker Service-replace walk-in cooler doors	2000	2,356	471	5	471		1,531		4
5	ABC -misc. construction work	2000	5,949	1,190	5	1,190		3,768		5
6	Equipment Int. -repair dryer	2000	1,036	207	5	207		656		6
7	Equipment Int. -repair dryer	2000	1,103	221	5	221		699		7
8	Equipment Int. -repair dryer	2000	1,103	221	5	221		699		8
9	Washtown Equipment (repair washers)	2001	572	191	3	191		556		9
10	CAPPS - Plumbing	2001	5,565	557	10	557		1,530		10
11	Alden Bennett Construction (carpeting)	2001	6,617	2,206	3	2,206		4,779		11
12	Alden Bennett Construction (misc. repairs)	2001	2,160	432	5	432		1,116		12
13	CAPPS - Plumbing (plumbing repairs)	2001	1,865	373	5	373		839		13
14	Long Elevator (car stations in two elevators)	2001	4,800	320	15	320		720		14
15	Fire Pros (fire alarm control panel upgrade)	2001	1,650	165	10	165		371		15
16	GT Mechanical (laundry exhaust fan for dryers)	2001	2,398	480	5	480		1,079		16
17	The Floor Source (carpeting in dining room)	2001	2,866	955	3	955		2,070		17
18	Capps - Plumbing (plumbing repairs)	2001	2,215	443	5	443		1,329		18
19	ABC - Parking lot Repair	2002	59,397	2,970	20	2,970		4,702		19
20	ABC - Misc. Repairs	2002	3,734	373	10	373		467		20
21	Alden Bennett Construction (carpeting)	2002	(6,617)	(2,206)	3	(2,206)		(4,411)		21
22	Capps Plumbing (hot water pump)	2002	1,885	377	5	377		628		22
23	Capps Plumbing (install new drain)	2002	1,685	337	5	337		534		23
24	GT Mechanical (condenser pump motor)	2002	2,505	251	10	251		397		24
25	Alden Bennett Construction (alarm annunciator)	2002	7,769	777	10	777		1,165		25
26	GT Mechanical (replaced motor)	2002	3,112	622	5	622		934		26
27	Alden Bennett Construction(chain link gate)	2002	2,565	513	5	513		770		27
28	GT Mechanical (replace motor)	2002	2,287	457	5	457		610		28
29	GT Mechanical (taco pump)	2002	3,808	381	10	381		508		29
30	Capps Plumbing & Sewer (handicapped accesible fountains	2002	2,500	250	10	250		292		30
31	New Horizons Communication (phone & jacks instal)	2002	3,651	365	10	365		396		31
32										32
33										33
34	TOTAL (lines 1 thru 33)		\$ 11,905,108	\$ 330,874		\$ 330,874		\$ 2,719,776		34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 11,905,108	\$ 330,874		\$ 330,874		\$ 2,719,776	1
2	Alden Bennett Construction (Automatic door op.eqpt)	2003	5,785	289	10	289		289	2
3	Alden Bennett Construction (3rd Floor remodelling)	2003	5,731	334	10	334		334	3
4	Alden Bennett Construction(elevator)	2003	2,595	173	5	173		173	4
5	CSI Coker Service (Refridgerator repairs)	2003	5,283	704	5	704		704	5
6	CSI Coker Service (kitchedn eqpt repairs)	2003	2,833	189	5	189		189	6
7	Patten CAT (AMS Billings)(engine reapears)	2003	1,598	80	5	80		80	7
8	GT Mechanical (plumbing reapiers)	2003	2,544	85	5	85		85	8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 11,931,477	\$ 332,727		\$ 332,727		\$ 2,721,630	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 11,931,477	\$ 332,727		\$ 332,727		\$ 2,721,630	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	16,755		20			16,755	4
5	Leasehold Improvement-Remodeling	1980	1,047		10			1,047	5
6	Leasehold Improvement-Remodeling	1986	559		5			559	6
7	Leasehold Improvement-Remodeling	1990	350		5			350	7
8	Leasehold Improvement-Remodeling	1991	82		5			82	8
9	Leasehold Improvement-Remodeling	1993	7,732		10			7,732	9
10	Leasehold Improvement-Remodeling	1993	6,056		9.7			6,056	10
11	Leasehold Improvement-sign	1994	226	14	12	14		120	11
12	Leasehold Improvement-dryvit	1995	384	24	10	24		203	12
13	Leasehold Improvement-new ac	1999	626	39	15	39		203	13
14	Leasehold Improvement-roof	1985	843	44	19	44		843	14
15	Leasehold Improvement-roof	1994	748	47	15	47		529	15
16	Leasehold Improvement-roof	1997	710	44	15	44		349	16
17	Leasehold Improvement-roof	1998	1,205	75	15	75		507	17
18	Leasehold Improvement-parking lot asphalt	2000	96	32	10	32		63	18
19	Leasehold Improvement-hallway lighting	2001	135	27	10	27		56	19
20	Leasehold Improvement-DAI	2001	169	17	10	17		53	20
21	Leasehold Improvement-bathrooms	2002	630	63	10	63		80	21
22	Leasehold Improvement-Remodeling	2002	91	18	5	18		36	22
23	Leasehold Improvements-Remodeling	2003	1,638	164	10	164		164	23
24	Leasehold Improvements-Remodeling	2003	105	4	4	4		4	24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	6,132		7			6,132	27
28	Leasehold Improvement-Remodeling	2002	5,020	627	7	627		4,392	28
29	Leasehold Improvement-Remodeling	2003	5,251	660	7	660		4,611	29
30									30
31									31
32									32
33		1999	15,137	378	40	378		1,896	33
34	TOTAL (lines 1 thru 33)		\$ 12,003,204	\$ 335,005		\$ 335,005		\$ 2,774,452	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 1,189,155	\$ 88,724	\$ 88,724	\$	varies	\$ 565,457	71
72	Current Year Purchases	64,913	4,639	4,639		varies	4,639	72
73	Fully Depreciated Assets	218,913	4,831	4,831		varies	218,913	73
74								74
75	TOTALS	\$ 1,472,981	\$ 98,194	\$ 98,194	\$		\$ 789,009	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	car enginew/bus/van	:dodge/other	98-'03	\$ 11,860	\$ 2,052	\$ 2,052	\$	3	\$ 11,658	76
77										77
78										78
79										79
80	TOTALS			\$ 11,860	\$ 2,052	\$ 2,052	\$		\$ 11,658	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 13,578,625	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 435,251	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 435,251	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 3,575,119	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	n/a	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92	n/a	\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party-cost is backed out.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 10,155 Description: copy machine lease = \$9,579 + postage meter rental = \$576

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>transport-non patients</u>	<u>various</u>	\$ <u>453.33</u>	\$ <u>5,440</u>	17
18					18
19	<u>related party - AMS</u>	<u>various</u>	<u>2,391.92</u>	<u>28,703</u>	19
20					20
21	TOTAL		\$ <u>2,845.25</u>	\$ <u>34,143</u>	21

10. Effective dates of current rental agreement:

Beginning November 1995

Ending October 2005

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ 932,028

13. /2005 \$ 776,690

14. /2006 \$ 0

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input type="checkbox"/> YES	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
<input checked="" type="checkbox"/> NO	IN-HOUSE PROGRAM <input type="checkbox"/>	IN-HOUSE PROGRAM <input type="checkbox"/>	
	IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>	
	COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE _____	
	HOURS PER AIDE _____		

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

Skilled nurses on site

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 334,003	\$		\$ 334,003	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			89,297			89,297	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			370,835			370,835	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Page 16A	# of prescrpts				220,806		220,806	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	See Page 16A					145,694		145,694	12
13	Other (specify):									13
14	TOTAL			\$		\$ 794,135	\$ 366,500		\$ 1,160,635	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

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Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 165,000)	1,510,395	1,510,395	3
4	Supply Inventory (priced at)	2,173	2,173	4
5	Short-Term Investments			5
6	Prepaid Insurance	7,184	55,887	6
7	Other Prepaid Expenses	29,805	29,805	7
8	Accounts Receivable (owners or related parties)	3,004,987	3,007,041	8
9	Other(specify): Due from 3rd parties/Rent Recei	29,408	619,351	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,583,952	\$ 5,224,652	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		310,554	13
14	Buildings, at Historical Cost		11,273,592	14
15	Leasehold Improvements, at Historical Cost	569,422	569,422	15
16	Equipment, at Historical Cost	491,003	1,351,066	16
17	Accumulated Depreciation (book methods)	(651,670)	(3,309,392)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds		71,348	21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Financing Fees		56,111	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 408,755	\$ 10,322,701	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,992,707	\$ 15,547,353	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 2,384,557	\$ 2,384,557	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	114,266	114,266	28
29	Short-Term Notes Payable	77,172	77,172	29
30	Accrued Salaries Payable	361,933	361,933	30
31	Accrued Taxes Payable (excluding real estate taxes)	17,315	17,315	31
32	Accrued Real Estate Taxes(Sch.IX-B)		584,100	32
33	Accrued Interest Payable		51,316	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	accr ins, exps, idpa, sales tax,etc	367,561	367,561	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,322,804	\$ 3,958,220	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	111,955	111,955	39
40	Mortgage Payable		9,774,465	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Due to affiliate		391,476	43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 111,955	\$ 10,277,896	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,434,759	\$ 14,236,116	46
47	TOTAL EQUITY (page 18, line 24)	\$ 1,557,948	\$ 1,311,237	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,992,707	\$ 15,547,353	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,938,946	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,938,946	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(380,998)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (380,998)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,557,948	24 *

* This must agree with page 17, line 47.

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 9,904,758	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 9,904,758	3
B. Ancillary Revenue			
4	Day Care	8,362	4
5	Other Care for Outpatients		5
6	Therapy	6,941	6
7	Oxygen	34,966	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 50,269	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,937	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	3,211	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,293	19
20	Radiology and X-Ray	(860)	20
21	Other Medical Services	71,369	21
22	Laundry	1,620	22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 80,570	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	313	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 313	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Various - See Attached	12,594	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 12,594	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 10,048,504	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,479,171	31
32	Health Care	3,453,781	32
33	General Administration	2,186,267	33
B. Capital Expense			
34	Ownership	2,203,421	34
C. Ancillary Expense			
35	Special Cost Centers	1,458,452	35
36	Provider Participation Fee	118,807	36
D. Other Expenses (specify):			
37	Related Party Salary Allocations		37
38	located in Column I on pages 3 & 4	(470,397)	38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 10,429,502	40
41	Income before Income Taxes (line 30 minus line 40)**	(380,998)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (380,998)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

STATE OF ILLINOIS

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Facility Name & ID Number Alden Poplar Creek Rehab & HCC

0032896

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,944	2,040	\$ 59,137	\$ 28.99	1
2	Assistant Director of Nursing	1,472	1,571	44,045	28.04	2
3	Registered Nurses	33,491	35,306	1,131,314	32.04	3
4	Licensed Practical Nurses	16,457	17,534	442,675	25.25	4
5	Nurse Aides & Orderlies	89,819	95,198	1,183,127	12.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	5,038	5,542	44,218	7.98	10
11	Social Service Workers	1,792	1,960	37,983	19.38	11
12	Dietician					12
13	Food Service Supervisor	2,100	2,180	31,492	14.45	13
14	Head Cook					14
15	Cook Helpers/Assistants	35,116	37,545	328,032	8.74	15
16	Dishwashers					16
17	Maintenance Workers	1,624	1,808	30,390	16.81	17
18	Housekeepers	19,135	20,445	168,793	8.26	18
19	Laundry	7,017	7,596	57,671	7.59	19
20	Administrator	1,704	1,840	83,967	45.63	20
21	Assistant Administrator					21
22	Other Administrative	7,496	8,244	188,773	22.90	22
23	Office Manager					23
24	Clerical	3,823	4,175	50,979	12.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	2,792	2,864	89,718	31.33	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>Alzheimers Super,</u>	8,741	9,445	95,143	10.07	33
34	TOTAL (lines 1 - 33)	239,561	255,293	\$ 4,067,457 *	\$ 15.93	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 10,799	1-3	35
36	Medical Director	Monthly	35,700	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	5,208	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	66	3,608	11-3	44
45	Social Service Consultant	12	660	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	78	\$ 55,975		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
A. Saltzman	Administrative	0	\$ 83,967	Workers' Compensation Insurance		\$ 95,040	IDPH License Fee		\$		
related party-various				Unemployment Compensation Insurance		17,933	Advertising: Employee Recruitment		413		
executives	exec mgmnt		99,945	FICA Taxes		309,310	Health Care Worker Background Check (Indicate # of checks performed 43)		301		
				Employee Health Insurance		20,735	II Health Care Assoc (less Pac portion)		8,187		
				Employee Meals		37,893	Surety Bond Fees, Dues & Subscriptions		3,383		
				Illinois Municipal Retirement Fund (IMRF)*							
				Union,Health, Welfare		141,135					
				Pension		31,361					
				dental & life insur		11,653	related party-ams		570		
				Marketing Empl. Benefits Deduction		(8,879)	Less: Public Relations Expense	(
				Relations, Misc Payroll,vaccinations/drug tests		3,373	Non-allowable advertising	(
				Attendance Bonus		22,152	Yellow page advertising	(
				related party-fecII & ams		66,492					
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 183,912	TOTAL (agree to Schedule V, line 22, col.8)		\$ 748,199	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 12,854		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**			
	Description		Amount	Description	Line #	Amount	Description		Amount		
			\$			\$	Out-of-State Travel		\$		
							In-State Travel				
							auto & travel		400		
							gasoline		3,128		
							related party-ams		12,621		
							Seminar Expense				
							American Express (Gold)		180		
							Entertainment Expense	(
							(agree to Sch. V,				
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 16,329		
C. Professional Services											
Vendor/Payee	Type		Amount								
AMS	Management Fees		\$ 591,600								
BDO Seidman	Accounting fees		10,196								
Ken Fisch	Legal Fees		27,709								
Schmidt Salzman & Moran	Legal Fees		100								
Medi.Com	Professional Fees		17,662								
Barry Greenburg	Legal Fees		2,751								
Janet Hermann	Legal Fees		1,304								
								</			

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
 (See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting	1988	\$ 4,226	5	\$	\$	\$	\$	\$	\$	\$	\$	
2	Service master	1988	3,962	10									
3	Complete Temp	1989	1,300	5									
4	Service master	1990	3,182	5									
5	CSI	1992	4,754	5									
6	Bob's painting	1993	1,460	5									
7	Bob's painting	1994	7,715	5		0							
8	Climate Service - insulation	1995	2,051	12	171	171	171	171	171	171	171		
9	Onassis - painting	11/95	1,339	3									
10	Totals from PG22a		78,377	3-15	15,984	14,143	7,878	5,165	3,034	2,836	862	420	
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 108,366		\$ 16,155	\$ 14,314	\$ 8,049	\$ 5,336	\$ 3,205	\$ 3,007	\$ 1,033	\$ 420	

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year	Total Cost										
		Improvement Was Made		Useful Life	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
21	PAINTING	5/95	840	3									
22	PAINTING	7/95	1,166	3									
23	INSTALL A/C MOTOR/HVAC	7/95	1,605	10	160	160	160	160	160	85			
24	PAINTING	9/95	1,535	3									
25	motor (hvac)	3/96	1,846	10	185	185	185	185	185	185	140		
26	hvac repair	6/96	2,283	10	228	228	228	228	228	228	130		
27	door	5/96	1,026	15	68	68	68	68	68	68	68	68	68
28	condensor	4/96	1,182	10	118	118	118	118	118	118	87		
29	hot water...	12/96	3,397	15	226	226	226	226	226	226	226	226	226
30	a/c repair	6/96	1,891	15	126	126	126	126	126	126	126	126	126
31	pump repair	8/96	1,988	10	199	199	199	199	199	199	85		
32	mixed air damper/hot wtr valve	4/97	1,853	3	154	0							
33	repair leaks in cooling syst	6/97	2,365	3	328	0							
34	replace tower motor-hvac	6/97	1,795	3	249	0							
35	pipe insulating	12/97	2,474	3	756	0							
36	CSI (belt on fan&airhandler)	4/98	1,811	3	604	151	0						
37	CSI (seal on condenser pump)	7/98	3,302	3	1,101	550	0						
38	CSI (replace recirculating pump)	8/98	2,350	3	783	457	0						
39	CSI (install vents off gas lines)	9/98	2,141	3	714	476	0						
40	PAINTING **	9/98	7,092	3	2,364	1,576	0						
41	PAINTING **	12/98	4,743	3	1,581	1,449	0						
42	Chicago Cooling(repair a/c)	6/99	1,998	3	666	666	278	0					
43	Onassis-painting(ytd>\$1,500) **	7/99	8,037	3	2,679	2,679	1,340	0					
44	Chicago Cooling(repair colling system)	02/00	3,416	3	1,044	1,139	1,139	94	0				
45	Capps-Plumbing & S.(repair water system)	06/00	1,511	3	294	504	504	209	0				
46	GT Mechanical (repair air handler)	10/00	2,820	3	235	940	940	705	0				
47	2000-painting(ytd>\$1,500) **	7/00	6,738	3	1,123	2,246	2,246	1,123	0				
48	2001 Capps (plumbing)	10/02	1,460	3			122	487	487	364			
49	TOTALS		74,666		15,984	14,143	7,878	3,928	1,797	1,599	862	420	420
** = reclassified from line 6 per cost report instructions (if interior painting is over 1,500 for the year, must put in def. Maint.													

** = reclassified from line 6 per cost report instructions (if interior painting is over 1,500 for the year, must put in def. Maint.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

[illegible]

** = reclassified from line 6 per cost report instructions (if interior painting is over 1,500 for the year, must put in def. Maint.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN, LPN, NA) represented by a union? yes
- (2) Are there any dues to nursing home associations included on the cost report? yes
If YES, give association name and amount. IL Healthcare Assoc. \$11,718
- (3) Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 30,172 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 118,807
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 37,893 Has any meal income been offset against related costs? no Indicate the amount. \$ n/a
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? no
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? no If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 0
d. Have vehicle usage logs been maintained? n/a
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? n/a
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? n/a
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? yes
Firm Name: BDO Seidman The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? no If no, please explain. not yet ready
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? yes
Attach invoices and a summary of services for all architect and appraisal fees.

Alden Nursing Center - Poplar Creek 003-2896
 Reporting Period Beginning 1/01/03
 Reporting Period Ending 12/31/03

Page 24

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(37,893)	Employee Meal
	22	37,893	Employee Meal
22		(6,703)	Uniforms
	10	4,209	Uniforms
	6		Uniforms
	4	285	Uniforms
	1	1,482	Uniforms
	3	540	Uniforms
	11	187	Uniforms
	21		Uniforms
<hr/>			
0			Net should be 0